STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085037	A. BUILDING _____ B. WING _____	C 03/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SHORES REHABILITATION & HEALTH CENTER	231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966

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F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from March 21, 2019 through March 27, 2019. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 168. The survey sample totaled 20. Abbreviations and Definitions used in this report are as follows: ADON - Assistant Director of Nursing; Arterial stenosis - narrowing of blood vessel that reduces blood flow below the narrowing; Arterial ulceration - open area on the skin due to lack of blood flow; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15. 13-15: Cognitively intact 08-12: Moderately impaired 00-07: Severe impairment CNA - Certified Nurse's Aide; Cognition - mental processes or thinking; Cognitively Impaired - abnormal mental processes/thinking OR mental decline including losing the ability to understand, talk or write; Cognitively Intact - able to make own decisions; Dementia - brain disorder with memory loss, poor judgement, personality changes and disorientation; DON - Director of Nursing; Extensive Assistance - resident involved in activity, staff provide weight-bearing support; Limited Assistance - resident highly involved in activity, staff provide guided movement of limbs	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/18/2019

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F 000	Continued From page 1 or other non-weight bearing assistance; LPN - Licensed Practical Nurse; MD - Medical Doctor; mg (milligrams) -unit of weight, 1 mg equals 0.0035 ounce; Moderate Cognitive Impairment - decisions poor, cues / supervision required; NHA - Nursing Home Administrator; Pain Scale - number scale to rate pain where 0 is no pain and 10 is the worst possible pain; PRN - as needed; QA - Quality Assurance; RN - Registered Nurse; SW - Social Worker; UM - Unit Manager; Venous ulceration - open area on the leg from swelling due to veins not returning blood to the heart from the legs.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		5/26/19

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F 584	Continued From page 2 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for ten out of fifteen bathrooms observed, the facility failed to provide a clean/comfortable and homelike environment. Findings include: The following observations were conducted during the survey: 3/22/19 (8:32 AM) - An observation of the bathroom in room 306 revealed a sticky floor with a strong smell of urine. 3/22/19 (8:36 AM) - An observation of the bathroom in room 121 revealed toiletries were strewn across the vanity, there were 5 dirty coffee cups on the vanity that were full of soapy water and a dirty sponge was in the bottom of the	F 584	The filing of this plan of correction does not constitute any admission as to any of the violations set forth in the statement of deficiencies. This plan of correction is being filed as evidence of the facility's continued compliance with all the requirements as of the completion date specified in the plan of correction for the noted deficiency. Therefore, the facility requests that this plan of correction serve as its allegation of substantial compliance with all the requirements as of 5/26/19.	

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F 584	Continued From page 3 shower. 3/22/19 (9:00 AM) - An observation of the bathroom in room 407 bathroom revealed a strong smell of urine. 3/22/19 (9:10 AM) - An observation of the bathroom in room 512 revealed a dirty floor and a strong smell of urine. 3/22/19 (9:11 AM) - An observation of the bathroom in room 501 revealed a dirty bathroom floor. 3/25/19 (11:25 AM) - An observation of the bathroom in room 102 revealed a strong smell of urine. 3/25/19 (11:31 AM) - An observation of the bathroom in room 113 revealed a dirty floor. 3/25/19 (11:33 AM) - An observation of the bathroom in room 122 revealed a dirty floor. 3/26/19 (9:48 AM) - An observation of the bathroom in room 714 revealed the toilet seat up and the bottom of the seat and the top of the bowl were splattered with dried bowel movement. There was also a dirty urinal on the floor on the left side of the toilet. 3/27/19 (9:45 AM) - An observation of the bathroom in room 303 revealed 3 bags of briefs on the bathroom floor, a dirty washcloth and towel in the sink, and an unlabeled, uncovered bedpan on the floor in the right hand corner next to the toilet. 3/27/19 (9:55 AM) - In an interview with E19 (CNA), the surveyor requested E19 to observe	F 584	A. -Room 306 bathroom was deep cleaned and is now free of urine smell. -Room 121 bathroom was cleaned and organized. Toiletries were organized and labeled. Shower area was cleaned and sponge discarded. -Room 407 bathroom was deep cleaned and is now free of urine smell. -Room 512 bathroom floor was deep cleaned and is now free of urine smell. -Room 501 bathroom floor was deep cleaned. -Room 102 was deep cleaned and now free if urine smell. -Room 113 bathroom floor was deep cleaned. -Room 122 bathroom floor was deep cleaned. -Room 714 toilet and bathroom floor was deep cleaned. Dirty urinal was discarded and replaced and bagged appropriately. -Room 303 bathroom was organized. Resident prefers bag of briefs near toilet for easy access but appropriate container was put in place. Bedpan was discarded, replaced with a new one, labeled and bagged. Trash can was emptied. -Affected bathrooms with persistent urine smell will also be treated with enzymatic agents for 2 weeks. Any bathrooms not free of urine smell after treatment, tiles will be replaced. B. All resident□s bathroom will be inspected by Environmental Services Director/Designee to ensure that bathroom floor is clean, free of urine	

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F 584	Continued From page 4 the bathroom in room 303 with the surveyor. When the surveyor inquired if E19 could identify any issues that might pose a problem, E19 replied, "there is a bedpan that should have been in a bag and labeled." E19 noted the dirty washcloth and towel in the sink, a trash can full of soiled incontinence products (for example, diapers or pull ups) next to a bag of clean incontinence products on the floor. E19 reported that it was the resident's preference to have his/her incontinent products next to the toilet for easy access, "but the trash can should have been emptied." 3/27/19 (12:15 PM) - In an interview and observation with E1 (NHA), E2 (DON), and E4 (SE), we entered the bathroom of room 512 and the above facility staff confirmed the strong smell of urine. The surveyor reported that there were other bathrooms that also had strong smells of urine and/or were not clean. The surveyor offered to tour the other bathrooms with facility staff, and E1, E2, and E4 declined to accompany the surveyor to visualize the other bathrooms. E2 commented, "We believe you." These findings were reviewed with E1 (NHA), E2 (DON) and E4 (QA RN) on 3/27/19 during the exit conference beginning at 11:45 AM.	F 584	smell, toilet is clean free of dried bowel movement. Unit Managers/Designee will inspect all bathrooms to ensure vanity is clean and organized, toiletries and bed pan labeled and bagged when not in use. Bathroom will also be checked to ensure trash cans are emptied after incontinent care is completed. -Bathrooms identified with persistent urine smell after cleaning will be treated with enzymatic agent for 2 weeks. Any bathrooms not free of urine smell after treatment, tiles will be replaced. C. Root cause analysis was conducted and identified for the deficient. Rooms identified were not thoroughly cleaned and are considered high risk rooms due to residents behaviors. Consistent bathroom deep cleaning was not followed. The following system changes will be initiated and maintained to prevent recurrence of the deficient practice. 1. Environmental Services Director/Designee will in-service his department and all new hires on how to appropriately maintain bathroom free of urine smell, floor and toilet. 2. Environmental Services Department (ESD) will utilize an enzymatic agent in bathrooms to ensure bathroom floor is clean and free of urine smell. 3. Monthly deep cleaning schedule of each bathroom will be maintained to ensure an ongoing process is in place to	

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F 584	Continued From page 5	F 584	prevent recurrence of non-compliance. 4. Environmental Services Department will provide extra attention on identified high risk resident□s bathroom due to a resident behavior which poses a higher risk of bathroom becoming dirty and presence of urine smell due to behaviors. The resident bathrooms were identified and an ongoing list of these bathrooms will be reviewed every week for any changes. 5. Staff Development/Designee will in-service nursing and rehab department and all new hires regarding maintaining the bathroom is organized after care such as used towels removed, trash discarded, toiletries labeled and organized in the room. In-servicing will focus on all toiletries labeled as soon as it is opened, used towels and linens for ADLs bagged and not left on floors, labeling and bagging of urinals and bedpans. -Issues listed above will be added to the facility Ambassador rounds sheets for weekly monitoring. D. -Daily random audit of 50% of all resident bathrooms by Environmental Services Director/Designee will be conducted to ensure bathrooms are free or urine smell, floor and toilet clean until 90% and higher compliance x 3 consecutively is achieved. Following will be a weekly random audit of 20% of all residents□ bathrooms, then monthly for the next quarter. Rooms identified to be non-compliant will be corrected on the	

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F 584	Continued From page 6	F 584	spot. In an event where reported non compliance is consistently below the goal, facility Interdisciplinary Team will meet (IDT) with QA committee to review the process and revisions will be made as necessary to maintain and sustain compliance goal. Audit report will be submitted to QA committee monthly. -Daily random audit of 50% of all residents bathroom by Unit Managers/Designee will be conducted to ensure bathrooms are organized after care by staff such as used towels removed, trash discarded, and toiletries labeled and organized in room until a 90% and higher compliance is achieved x 3 consecutively. Following will be a weekly random audit of 20% of all resident□s bathroom and then monthly for the next quarter with a goal of 90% compliance or higher. Rooms identified to be non-compliant with the plan of correction will be corrected on right away. In an event where reported non compliance is consistently below the goal, facility IDT will meet with QA committee to review the process and revisions will be made as necessary to maintain and sustain compliance goal. Audit report will be submitted to QA committee monthly.	
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		5/26/19

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F 609	Continued From page 7 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documents, it was determined that the facility failed to identify and immediately report allegations of abuse and/or neglect for 6 (R4, R10, R17, R18, R19 and R20) out of 11 residents investigated for abuse and/or neglect. R10's complaint about intimidation and the fear of using the call bell was not identified as an allegation of mental abuse. During the investigation of R4's allegation of mental abuse, the facility failed to identify an allegation of neglect for R4 The facility failed to identify an allegation of mental abuse for R17, R18 and R19. For R20, the staff member who was aware of the physical abuse failed to report the allegation to administration for two days. Findings include:	F 609	A. -R4 is no longer in the facility. - Staff involved in the allegation for R10 no longer works in the facility. -R17 is no longer n the facility. Staff involved no longer works in the facility -Staff involved for R18 incident no longer works in the facility. -R19 is no longer in the facility. -Staff member who was aware of the allegation for R20 was educated on 4/17/19. The same staff will be re in-serviced during the facility wide in-service. B. Facility Nursing Home Administrator	

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F 609	Continued From page 8 Review of the facility policy entitled Abuse Policy and Procedure (last revised 3/7/18) documented that each resident had "the right to be free from verbal, sexual, physical and mental abuse...mistreatment, neglect..." The policy defined physical abuse as "includes, but is not limited to, hitting, slapping, pinching, kicking, etc. It also includes control of resident's behavior through corporal punishment." Mental abuse was defined as "includes, but not limited to: resident humiliation, intimidation, threatening demeanor, harassment, and threats of punishment or withholding a treatment, services, or privileges." The policy defined neglect as "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress." The procedure described in the policy included: - "Employees are obliged to anticipate resistant or combative behavior from individual residents and to approach them in a manner that will prevent or reduce such behavior. This information shall be placed in the resident's care plan and communicated to appropriate staff.." - "On any occasion when employees may be called upon to defend themselves or others from disturbed individuals, each employee must show maximum self-control and self-discipline to ensure s/he uses only the minimum amount of defensive force necessary in a given situation. These situations must be reported immediately." - "Any resident, responsible party, interested family member, or advocate who has witnessed or has knowledge of an alleged abuse, neglect or	F 609	and DON/Designee will review all investigations conducted in the past 14 days to ensure that: - staff interviews during the course of the investigation that may imply an allegation of abuse is/was reported. - reported cases were reported comprehensively. C. Root cause analysis was conducted and identified for the deficient practice. Investigation statements were not thoroughly reviewed during the investigation process. Staff did not report timely upon hearing of the allegation. The following system change will be initiated and maintained to prevent recurrence of deficient practice. 1. All Staff and new hires will be in-serviced by Staff Development/Designee to ensure allegations of abuse and neglect are reported and in a timely manner. Staff will also be in-serviced on Facility□s Neglect and Abuse Policy and aspects of reporting. Focus of the in-service will be the identification of an allegation of abuse and neglect and the timely reporting. 2. All investigations of Abuse and Neglect will be reviewed by NHA/DON/Designee to ensure statements are reviewed thoroughly and cases reported timely. 3. Facility IDT will discuss daily in morning meeting resident concerns. D. Daily audit of all allegations of Abuse	

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F 609	Continued From page 9 misappropriation of property or has a concern about treatment, medical care, behavior of other residents or staff members may file a grievance or complaint without fear of threat or reprisal in any form." - "A person shall not knowingly fail to report an incident or mistreatment or other offense." - The facility will "report allegations of abuse, neglect, exploitation or mistreatment immediately to the Administrator, DON or designee and the State Survey Agency." The facility will "report these allegations immediately but no later than 2 hours of [sic] any allegation which includes injuries of unknown source...if the events that cause the allegation involve abuse..." 1. Review of R10's records revealed: 11/26/18 - R10 was admitted to the facility from the hospital for rehabilitation. 12/4/18 - Nurse Practitioner (NP) note: E22 (NP) wrote that R10's judgement and insight was appropriate, short-term recall was normal and that R10 was oriented to person, place, month and year. 12/4/18 - R10's family member filed a written grievance with the facility requesting that E10 (CNA), who worked the 3p - 11p shift, no longer provide care to the resident because: -R10 was scared from 3p - 11p to ring the bell for assistance, -R10 was scared that by saying something about E10's behavior "it will get much worse", and -R10 was so upset that the family member fears he/she would have another stroke. Examples included in this grievance were that	F 609	and Neglect/grievances that may imply allegation of abuse/neglect will be reviewed and audited by NHA/DON/Designee to ensure statements are appropriately addressed until 100% compliance x3 of all allegations is achieved. Following will be a weekly audit of all allegations of Abuse and Neglect/grievances will be audited x 4 with the goal of 100% compliance. Following will be a monthly audit of 50% sample of all grievances and allegations of abuse and neglect will be conducted with a 100% compliance goal each month. Any audit report identified as non-compliant, immediately upon identification, appropriate action will be initiated. In an event where audit results resulting in continued non compliance lower than the 100% goal, facility IDT and QA committee will meet; process will be reviewed and revised accordingly to improve and sustain compliance. Audit report will be submitted to QA committee monthly.	

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F 609	Continued From page 10 E10 "always has an attitude", "is very nasty" to R10, and refused or delayed providing care when requested. 12/4/18 - Facility's Investigation: E2 (DON) wrote that she met with R10 and the family member who made the grievance and discussed details of the incident. E2 wrote that both were pleased with the plan that E10 (CNA) will not be taking care of R10. 12/5/18 - Facility's Investigation: E2 (DON) wrote that he/she spoke with E10 (CNA) who said E10 was going through a lot and felt the need to change his/her profession. E10 stated he/she was getting tired of healthcare and that, "it was a very busy night with one resident being agitated so we were dealing with that and probably I was trying to rush to [get] things done that night." The plan was for the staff development educator to provide 1 on 1 in-service education with E10. 1/14/19 - Human Resource records revealed that the facility terminated E10 (CNA) for "intimidating or coercing residents and inconsiderate, rude and discourteous behavior." 3/20/19 Psychologist note: E21 (Psychologist) wrote that R10 expressed anxiety about possible retaliation from staff. The facility failed to identify R10's grievance as an alleged violation involving neglect and mistreatment and they failed to immediately report the allegations of mental abuse to the State agency. Findings were reviewed with E1 (NHA), E2 (DON) and E4 (QA RN) on 3/27/19 during the exit conference beginning at 11:45 AM.	F 609		

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F 609	Continued From page 11 2. Review of R4's clinical record revealed: 12/9/18 - The admission MDS assessment revealed that R4 was cognitively intact with a BIMS score of 15 out of 15. Review of the facility's investigation for R4's allegation of mental abuse revealed: 1/12/19 (11:00 PM) - E11's (LPN) written statement included that R4 informed E11 around 9:30 PM that E10 (CNA) told R4 to "not call or bother the CNA until after 10:00 PM." E11 wrote that he/she informed E10 not to enter R4's room because the two resident's in that room were assigned to a different CNA. R19 (roommate of R4) informed E11 that he/she "had a list a mile long with [E10's first name] complaints." Undated/untimed - E10's (CNA) written statement included, "It was said that I told a resident not to put on a call bell...I didn't speak of any of that to my residents, and I'm not gonna [going] be blamed." Undated/untimed - E10's (CNA) written statement documented that E10 "went on lunch about 8:30 PM" and when returning from break, E10 was "stopped in my tracks from [by the] nurse [E11] saying I couldn't go into that room...neither nurse [E11] nor supervisor [E12] wanted to discuss with me, I know it was in regards to call bell." E10 described a "joking conversation" with R4 "about me being with her all night, telling [R4] to save her chair that is next to [his/her] bed for me, letting [him/her] know I'll be right next to him/her to where [he/she] won't have to put the [call] bell on."	F 609		

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F 609	Continued From page 12 1/13/19 (untimed) - E12's (RN Supervisor) written witness statement described interviews from four residents, including that R4 was upset and stated that E10 (CNA) was rude, told him/her to stop ringing his/her call bell, told R4 that E10 knew when care was needed and told R4 that your [you're] getting on my nerves." R4 added that when ringing the call bell again to inform E10 he/she was soiled, the "CNA came in room and again hollered at R4 to stop ringing bell and E10 would come back and clean him/her. The CNA returned 45 minutes later leaving R4 in soiled clothing and bed linen." E10 (CNA) was the same CNA involved in intimidating R10 (example #1) the month before and who stated he/she felt the need to change his/her profession and was getting tired of healthcare. 1/14/19 - Human Resource records revealed the facility terminated E10 (CNA) for "intimating or coercing residents and inconsiderate, rude and discourteous behavior." 3/26/19 (12:42 PM) - E23 (Scheduler) printed a copy of E10's (CNA) time punches from 1/12/19 which revealed E10's meal break was from 7:00 PM to 7:30 PM. E23 confirmed that E10 clocked out at 11:15 PM. E10 worked for nearly two hours after E11 (LPN) became aware of the allegation of mental abuse. The facility failed to identify R4's allegation of neglect when the resident was left soiled for 45 minutes as described in E12's (RN Supervisor) written witness statement, as only the allegation of mental abuse (related to the call bell) was included in R4's investigation packet from the 1/12/19 allegation. This resulted in failure of the	F 609		

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facility to immediately report the allegation of neglect immediately to the State Agency and to protect other residents from neglect while E10 (CNA) continued to work.

Findings were reviewed with E1 (NHA), E2 (DON) and E4 (QA RN) on 3/27/19 during the exit conference beginning at 11:45 AM.

3. Review of R19's clinical record revealed:

1/4/19 - The admission MDS assessment documented that R19 was cognitively intact with a BIMS score of 15 out of 15 and received limited assistance with one staff for transfers and toileting.

Review of facility documents related to R19's allegation of mental abuse revealed:

1/13/19 (untimed) - E12's (RN Supervisor) written witness statement described interviews from four residents including that R19 reported "E10 (CNA) was angry about patient ringing call bell for help, told patient to stop ringing call bell and not returning to help patient."

E10 (CNA) was the same CNA involved in intimidating R10 (example #1) the month before and who stated he/she felt the need to change his/her profession and was getting tired of healthcare.

1/14/19 - Human Resource records revealed the facility terminated E10 (CNA) for "intimidating or coercing residents and inconsiderate, rude and discourteous behavior."

3/26/19 (around 10:00 AM) - During an interview with E2 (DON), when asked if an allegation of

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mental abuse was identified for R19, E2 stated that all residents under the care of E10 (CNA) were interviewed the next morning (1/13/19). E2 said E10 was educated that it was not appropriate to tell residents not to use their call bells since the CNA was there and knew how to care for the residents. E2 stated he/she "thought it was resolved at that time" and did not look into the allegation.

3/26/19 (12:42 PM) - E23 (Scheduler) printed a copy of E10's (CNA) time punches from 1/12/19 which revealed and, E23 confirmed, that E10 clocked out at 11:15 PM. E10 worked for nearly two hours after E11 (LPN) became aware of the allegation of mental abuse for R19.

The facility failed to identify R19's allegation of mental abuse as described in E12's (RN Supervisor) written witness statement. This failure to identify an allegation of mental abuse resulted in failure to immediately report the allegation to the State Agency and to protect residents from mental abuse.

Findings were reviewed with E1 (NHA), E2 (DON) and E4 (QA RN) on 3/27/19 during the exit conference beginning at 11:45 AM.

4. Review of R17's clinical record revealed:

2/16/19 - The admission MDS showed R17 had a BIMS score of 13 out of 15 (cognitively intact) and received extensive assistance of one staff for transfer and toileting.

Review of facility documents related to R17's allegation of mental abuse revealed:

1/12/19 (10:00 PM) - E11's (LPN) written

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statement included that E 11 overheard R17's roommate (R18) "talking on the telephone about being upset with how staff was treating" his/her roommate (R17). R17 explained to E11 that after he/she informed E10 (CNA) of the need to use the bathroom E10 said he/she would "be right back" and never returned. R17 re-activated the call light and when E10 responded the CNA "was agitated" and said he/she "could put the resident on the toilet but would not be able to get him/her off." E11 informed E12 (RN Supervisor).

Undated/untimed - E13's (CNA) written statement included, "I signed out on my 30 minute break at 7:45 PM and returned at approx [approximately] 8:15 PM - 8:20 PM. Upon returning to the unit, R17 was in the bathroom with call light on. I immediately helped said (sic) resident off the toilet and back to bed."

1/13/19 (untimed) - E12's (RN Supervisor) written witness statement included that R17 stated, "R10 (CNA) entered his/her room when he/she rang call bell, took call bell away...and told him/her to stop ringing and that R10 would come back."

E10 (CNA) was the same CNA involved in intimidating R10 (example #1) the month before and who stated he/she felt the need to change his/her profession and was getting tired of healthcare.

1/14/19 - Human Resource records revealed the facility terminated E10 (CNA) for "intimidating or coercing residents and inconsiderate, rude and discourteous behavior."

3/26/19 (around 10:00 AM) - During an interview with E2 (DON), when asked if an allegation of mental abuse was identified for R17, E2 stated

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that all residents under the care of E10 (CNA) were interviewed the next morning (1/13/19). E2 said E10 was educated that it was not appropriate to tell residents not to use their call bells since the CNA was there and knew how to care for the residents. E2 "thought it was resolved at that time" and did not look into the allegation.

3/26/19 (12:42 PM) - E23 (Scheduler) printed a copy of E10's (CNA) time punches from 1/12/19 which revealed and, E 23 confirmed, that E10 clocked out at 11:15 PM. E10 worked for nearly two hours after E11 (LPN) became aware of the allegation of mental abuse.

The facility failed to identify R17's allegation of mental abuse as described in E12's (RN Supervisor) written witness statement. This failure to identify an allegation of mental abuse resulted in the facility's failure to immediately report the allegation to the State Agency and to protect residents from mental abuse.

Findings were reviewed with E1 (NHA), E2 (DON) and E4 (QA RN) on 3/27/19 during the exit conference beginning at 11:45 AM.

5. Review of R18's clinical record revealed:

11/10/18 - The quarterly MDS assessment showed R18 had moderate cognitive impairment with a BIMS score of 11 out of 15 and received extensive assistance with one staff for transfer and toileting.

Review of facility documents related to R18's allegation of mental abuse revealed:

1/13/19 (untimed) - E12's (RN Supervisor) written witness statement included that R18 "stated that

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F 609	Continued From page 17 he/she was also told by R10 (CNA) to not ring [his/her] call bell." E10 (CNA) was the same CNA involved in intimidating R10 (example #1) the month before and who stated he/she felt the need to change his/her profession and was getting tired of healthcare. 1/14/19 - Human Resource records revealed the facility terminated E10 (CNA) for "intimidating or coercing residents and inconsiderate, rude and discourteous behavior." 3/26/19 (around 10:00 AM) - During an interview with E2 (DON), when asked if an allegation of mental abuse was identified for R18, E2 stated that all residents under the care of E10 (CNA) were interviewed the next morning (1/13/19). E2 said E10 was educated that it was not appropriate to tell residents not to use their call bells since the CNA was there and knew how to care for the residents. E2 "thought it was resolved at that time" and stated he/she did not look into the allegation. 3/26/19 (12:42 PM) - E23 (Scheduler) printed a copy of E10's (CNA) time punches from 1/12/19 which revealed and, E 23 confirmed, that E10 clocked out at 11:15 PM. E10 worked for nearly two hours after E11 (LPN) became aware of the allegation of mental abuse. The facility failed to identify R18's allegation of mental abuse as described in E12's (RN Supervisor) written witness statement. This failure to identify an allegation of mental abuse resulted in failure of the facility to immediately report the allegation to the State Agency and to protect residents from mental abuse.	F 609		

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Findings were reviewed with E1 (NHA), E2 (DON) and E4 (QA RN) on 3/27/19 during the exit conference beginning at 11:45 AM.

6. Review of R20's clinical record and other facility documentation revealed:

12/28/17 - R20 was admitted to the facility with diagnoses that included dementia with behavioral disturbance.

1/6/19 (2:45 PM) - In a progress note written by E15 (LPN), E15 documented, "(R20) hitting and spitting at staff grabbing things throwing things and tearing up anything he/she could, (R20) very hard to redirect. Offered snacks, and hydration but (R20) refused."

1/8/19 (1:18 PM) - A facility incident report submitted to the state agency by E3 (ADON) included: "At approximately 11:00 AM a staff member reported that he/she had been told that an employee had grabbed a resident around his/her neck on 1/6/19." The incident report was submitted two days after facility staff became aware of the occurrence. The allegation of physical abuse should have been reported within 2 hours.

1/8/19 - A written statement by E18 (CNA), included, "I was working 7-3 (shift) on station three. I was at the kiosk [computer] by the double doors closest to station four. I didn't visual (sic) see anything, but I heard everyone at the desk gasp. I asked what happened and the only knowledge I have is hearsay, which was that (E15, LPN) was smacked by (R20) and (E15) in return grabbed (R20's) face and pushed (R20's) face back."

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F 609	Continued From page 19 1/8/19 - A written statement by E16 (CNA) included, "I was doing my book, (R20) grabbed (E15, LPN) behind (his/her) neck so fast, and then (E15) turned around (and) grabbed (R20) and told (R20) to never do it again." 1/8/19 - A written statement by E15 (LPN) included, "Nurse (E15) turned the office (spin) chair seat around and could not slide out because his/her chair in the way, and noticed it was (R20) and (R20) was swinging. As I stood I put my hand on chair arm to block (R20's) left arm from swing (sic), and held (R20's) face with my right hand so I could look at (R20) and get (his/her) attention." 1/9/19 - A typed interview conducted with the other nurse on duty, E17 (LPN) by E3 (ADON) included, "(E17) reported that the other nurse (E15, LPN) turned in her chair and tried to calm (R20) down. (E17) reported that (E15) put (his/her) hand on the resident's face and cheek and told (R20) that (he/she) couldn't do that, referring to (R20) hitting and scratching people." The facility staff failed to identify an allegation of physical abuse and to immediately report it to administration and the State Agency and failed to protect residents from physical abuse. These findings were reviewed with E1 (NHA), E2 (DON) and E4 (QA RN) on 3/27/19 during the exit conference beginning at 11:45 AM.	F 609		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice,	F 697		5/26/19

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F 697	Continued From page 20 the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to perform pain assessments according to the plan of care for one (R6) out of five residents investigated for neglect / failure to provide services. Findings include: The facility policy entitled Pain - Clinical Protocol (revised 9/25/18), included that staff will reassess the individual's pain and related consequences at regular intervals, at least each shift for acute pain or significant changes in levels of chronic pain. Staff will assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level (numeric or PAINAD - Pain Assessment in Advanced Dementia)...staff will observe the resident (during rest and movement) for evidence of pain: for example, grimacing while being repositioned or having a wound dressing changed, increased movements, transferring and ambulation... Review of R6's clinical record revealed: 1/28/17- A care plan for pain included the goal for relief 30-60 minutes after intervention. R6's goal was 0 (zero). 2/26/18 - There was a physicians' order for a pain evaluation every shift and to document verbal / non-verbal signs of pain. 1/7/19 - A physician progress note by E24 (MD) noted R6's left leg / foot with some pain in toes. R6's acceptable level of pain was 0 (zero).	F 697	A. Resident #6 is no longer in the facility. No further action needed. Staff (LPN) involved clarified that the documentation was incorrectly coded when resident is asleep at night in the Electronic Medication Administration Record (EMAR). Staff was educated on 3/28/19 for accurate documentation. The same staff will be re-educated during the facility wide in-servicing. B. All active residents□ (EMAR) will be reviewed within the last week to ensure staff are documenting their pain assessment every shift. C. Root cause analysis was conducted and identified for the deficient practice. The staff was incorrectly coding in the electronic Medication Record (EMAR) causing the coding to coded as an "X" instead of coding a zero when resident is asleep. The following system change will be initiated and maintained to prevent recurrence of deficient practice. 1. Licensed Nursing staff and all new hires will be in-serviced by Staff Development/Designee regarding appropriate documentation in the EMAR related to pain assessment. An actual demonstration of the pain documentation in the EMAR will be covered during the in-service. Pain assessment/documentation will be added to new hire orientation for verification of	

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F 697	Continued From page 21 1/9/19 - A podiatry (foot doctor) progress note indicated that R6 had moderate to severe foot / toe pain for about a week. 1/17/19 - 2/4/19 - Review of nurses' notes and eMARs revealed: - R6 had purulent drainage (pus) on the nail bed of the left great (first) and second toe which was treated with an antibiotic. - R6's left leg had arterial stenosis and became swollen, leaking fluid through the skin and he/she developed several blisters. - R6 received two tablets of a pain medication (Tramadol) at bedtime starting 1/31/19 since R6 said "Tylenol does not work." - After R6 stated he/she was "always in pain," a tablet of Tramadol was added to be given every morning starting on 2/1/19. 2/5/19 - A wound evaluation note revealed that R6's great toe had gangrene (dying tissue). 2/11/19 - R6 returned from the hospital on hospice after refusing to have the dying toe / foot removed. Admission physicians' orders for pain management included: - Tylenol every 6 hours as needed (PRN) for mild pain. - Tramadol every 6 hours PRN for moderate pain. - Morphine (strong pain medication) 5 mg every 4 hours as needed (PRN) for pain. 2/11/19 - A care plan for hospice included an intervention to observe for and report comfort needs. 2/12/19 - Physicians' orders increased the dose and frequency of the Morphine to 10 mg every 2 hours PRN.	F 697	competency. The same competency will be reviewed annually. D. Daily random audit of 50% of all active residents will be conducted by Unit Manager/Designee to ensure that staffs are documenting appropriate response in the EMAR until 90% compliance or higher is achieved x 3. Following will be a 20% sample of all active residents will be weekly x 4, then monthly for the next quarter with the same compliance goal. Any reported non-compliance will be corrected appropriately. In an event where compliance rate is below the 90% goal, facility IDT will meet with QA committee and process will be re-evaluated and revised as needed to sustain compliance. Audit result will be submitted to QA committee monthly.	

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2/13/19 - A care plan for pain had the goal to keep pain at a tolerable level (no specific pain goal was identified, goal from 2017 pain care plan was zero). Care plan interventions included: Administer pain medications per physicians' orders and observe for effectiveness; and Administer treatment per physician orders.

2/13/19 - A care plan for arterial ulceration left lower extremity and venous ulceration to the right leg, included the goal to keep pain relieved to a tolerable level ... No pain score was identified as R6's goal in the care plan.

2/19/19 - A physician progress note documented, "inadequate pain control with PRN morphine. Was in significant pain this am (morning) when 7-3 nurse arrived. Relieved with morphine." The physician ordered:
- Morphine 10 mg to be given routinely every 4 hours and
- Morphine 10 mg every 1 hour PRN.

Review of R6's February, 2019 eMAR and nurses' notes showed between 2/11/19 - 2/21/19:
- Pain evaluation was not assessed 9 out of 11 times on night shift.
- PRN Morphine administrations were between 7:39 AM and 10:27 PM (none on night shift).
- Nurses' notes describing R6's pain management were written between 7:47 AM and 10:14 PM (none on night shift).

3/26/19 (9:15 AM) - During an interview with E2 (DON and E4 (QA RN), R6's pain management was reviewed.

3/27/19 (8:47 AM) - During an interview with E9 (LPN) to discuss R6's pain management, E9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085037	A. BUILDING _____ B. WING _____	C 03/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SHORES REHABILITATION & HEALTH CENTER	231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 23 stated R6 was in a lot of pain on 2/19/19. "I had been off a few days and noticed [R6] was worse when I came back. [R6] was down the hall so we usually didn't start with [his/her] room." E9 added that R6's daughter was visiting and "approached me to see if [R6] had medicine the night before. I looked and saw [R6] didn't. I assessed [R6] and gave medicine right away then called the doctor for a routine order since PRN was not consistently given at night." E9 revealed that R6 had become non-verbal by 2/29/19, but R6 "had signs of pain including moaning, agitation and wincing with dressing change." The findings were reviewed with E1 (NHA), E2 (DON) and E4 (QA RN) during the exit conference on 3/27/19 beginning at 11:45 AM. 3/28/19 (10:36 AM) - In an email, E2 (DON) wrote that E26 (LPN), the full-time night shift nurse, entered "not applicable" for R6's pain evaluation if the resident was asleep or not complaining of pain. The facility failed to assess R6's pain on 9 out of 11 night shifts as R6's gangrene progressed and the tissue in his/her toe / foot deteriorated and died. This resulted in the failure of the facility to identify verbal / nonverbal signs that R6 was in pain and if R6 needed PRN pain medication during the night.	F 697		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Atlantic Shores

DATE SURVEY COMPLETED: March 27, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from March 21, 2019 through March 27, 2019. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 168. The survey sample totaled 20.	The filing of this plan of correction does not constitute any admission as to any of the violations set forth in the statement of deficiencies. This plan of correction is being filed as evidence of the facility's continued compliance with all requirements as of the completion date specified in the plan of correction for the noted deficiency. Therefore, the facility requests that this plan of correction serve as its allegation of substantial compliance with all requirements as of 5/31/19.	
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey completed March 27, 2019: F584, F609, and F697.	Cross refer to plan of correction CMS 2567-L survey completed 3/27/19 for Federal Tags: F584, F609, F697.	

Provider's Signature Linda Murray Dir Title Administrator Date 4/18/19